MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05638

CERTIFICATE OF DEATH

05633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 1½ years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Fullen Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arbutus
   d. STREET ADDRESS: 5552 Dolores Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ANNIE Middle GRACE Last BIDGOOD

4. **DATE OF DEATH**: Month May Day 4 Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 28, 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas A. Bidgood

14. MOTHER'S MAIDEN NAME: Ella T. March

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr Vincent C. Bidgood. Address: as above

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis, Cardiac failure
420.1
DUE TO (b): Arteriosclerosis generalized.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1961 to 5-4-62

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1961, 19..... to 5-4-62, 19....., that (I) (we) last saw the deceased alive on 5-4-62 19....., and that death occured at 8:00 A.M. from the causes and on the date stated above.

22e. SIGNATURE: Howard E Hall M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-5-62

22c. PHYSICIAN'S NAME (Type): HOWARD E. HALL

22d. ADDRESS: SYKESVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 6, 1962

23c. NAME OF CEMETERY OR CREMATORY: Churchland Baptist

23d. LOCATION (City, town or county) (State): Churchland, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Kirwan

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05639

CERTIFICATE OF DEATH

05634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 21 yrs. 5 mos. 13 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — 0102-2
   d. STREET ADDRESS: 18½ N. Lee St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Clarence — Middle: Theodore — Last: Bolyard

4. **DATE OF DEATH**: Month: May — Day: 22, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 12, 1904

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Millard Bolyard

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lung, terminal phase — INTERVAL BETWEEN ONSET AND DEATH: Months

163X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, catatonic type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 9, 1940 to May 22, 1962, that (I) (we) last saw the deceased alive on May 22, 1962, and that death occured 12:10PM from the causes and on the date stated above.

22a. SIGNATURE: Adnan Sonmez M.D. — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/22/62

22c. PHYSICIAN'S NAME (Type): Adnan Sonmez, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 25, 1962

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

23d. LOCATION (City, town or county) (State): Elk Garden, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Byron Knight — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR: MAY 25 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Kimes

VR A15 (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05640

CERTIFICATE OF DEATH

05635 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b 6 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROUTE 4

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster X
d. STREET ADDRESS R4
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print) First LEWIS Middle MAYS Last BOND, Jr.

4. DATE OF DEATH Month MAY Day 19 Year 1962

5. SEX M
6. COLOR OR RACE W
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC 28-1909
9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLANT SUPT
10b. KIND OF BUSINESS OR INDUSTRY Ready Mixed Concrete
11. BIRTHPLACE (State or foreign country) BALTO. Co. MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME THOMAS B BOND
14. MOTHER'S MAIDEN NAME JANE MAYS.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 1/26- 1944-1945
16. SOCIAL SECURITY NO. 220-05-9411
17. INFORMANT Address MRS MARY BOND, R4. WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRACHEO-ESOPHAGEAL FISTULA — INTERVAL BETWEEN ONSET AND DEATH 3 MO.

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) CARCINOMA OF LUNG — 3 yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAR 6, 1962 to MAY 19, 1962, that I last saw the deceased alive on MAY 18, 1962, and that death occurred at 1:35 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE James T. March M.D. ADDRESS (Street, city or town, state) 105 E. MAIN ST DATE SIGNED 5/19/62

PHYSICIAN'S NAME (Type) JAMES T. MARCH WESTMINSTER MD

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 5-22-62
22c. NAME OF CEMETERY OR CREMATORY Jessop Methodist Cemetery
22d. LOCATION (City, town, or county) (State) COCKEYSVILLE, Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook-Towson, Inc., 1050 York Road, TOWSON
24a. REC'D BY REGISTRAR DATE MAY 22 '62
24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05641

CERTIFICATE OF DEATH

05636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 18 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring — 1515-2
   d. STREET ADDRESS: 707 Rossmere Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Eva — Middle: Louise — Last: Bonifant

4. **DATE OF DEATH**: Month: May — Day: 21 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Gittings

14. MOTHER'S MAIDEN NAME: Maggie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic gangrene, right leg — Weeks

260 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis and Diabetes — Years
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with cerebral arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 3, 19 62 to May 21, 19 62, that (I) (we) last saw the deceased alive on May 21, 19 62, and that death occured at 11 pM, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-22-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 24, 1962

23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery

23d. LOCATION (City, town or county) (State): Prince George County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Ahlers by Day — ADDRESS: 25th & Canal St. N.W. Washington 12, D.C.

25a. REC'D BY REGISTRAR DATE: MAY 24 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05642

CERTIFICATE OF DEATH

05637

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Woodbine
   c. LENGTH OF STAY IN 1b: life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R. D. 1-- Near Winfield

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural-- Woodbine
   d. STREET ADDRESS: R. D. 1--Near Winfield
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First ROBERT — Middle W. — Last BOWER

4. **DATE OF DEATH**: Month MAY — Day 24 — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 18, 1912

9. AGE (In years last birthday): 49 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas M. Bower

14. MOTHER'S MAIDEN NAME: Eva Conaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Tresa C. Bower, Same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

342X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Brain abscess — unknown

DUE TO (c): Meningitis — 4 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/22/62, 19..., to 5/24, 19 62, that (I) (we) last saw the deceased alive on 5/24 1962, and that death occured at 5P M, from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/25/62

22c. PHYSICIAN'S NAME (Type): Julius Chepko, M. D.

22d. ADDRESS: 85½ W. Green St., Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-26-1962

23c. NAME OF CEMETERY OR CREMATORY: Lakeview Mem. Gardens

23d. LOCATION (City, town or county) (State): Carroll Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Box 241--Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 28 '62

25b. REGISTRAR'S SIGNATURE: Curtis L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05643

CERTIFICATE OF DEATH

05638

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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1

1012

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 8 das. / 1 yr./6 mos.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Westminster
   d. STREET ADDRESS: 70 Madison St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Rydie — Middle: Lee S. — Last: BROWN

4. **DATE OF DEATH**: Month: May — Day: 26, — Year: 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ Sep.

8. DATE OF BIRTH: 1 - 15 - 86

9. AGE (In years last birthday): 76 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Spalding

14. MOTHER'S MAIDEN NAME: Hattie Nichols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Springfield State Hosp. Records - Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mycardial infarction due to — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary occlusion. — hours
DUE TO
(c) Arteriosclerotic heart disease. — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychoneurotic Disorder, Depressive reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-18-60, 19..., to 5-26-62, 19..., that (I) (we) last saw the deceased alive on 5-26-62 19..., and that death occured at 1:05 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/26/62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/29/62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel

ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE MAY 31 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

Wm. G. Hoop

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05644 — 05639 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Adam Convalescent

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa
b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover — 75X3
d. STREET ADDRESS: 327 N. Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Louise — Last: Coley

4. DATE OF DEATH: Month: May — Day: 31 — Year: 1962

5. SEX: F

6. COLOR OR RACE: Wh

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/16/1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Adams Co Pa

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph Coel

14. MOTHER'S MAIDEN NAME: Annie King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Sterling Helwig — Address: 26 W. Hanover St. Hanover Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Several yrs
DUE TO (b): Arteriosclerosis (Gen'l) — Several yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from June, 1960, to May 31, 1962, that I last saw the deceased alive on May 31, 1962, and that death occurred at 10:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Glenn Speicher, M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 6/1/62

PHYSICIAN'S NAME (Type): W. Glenn Speicher

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 6/4/62 — 22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet — 22d. LOCATION (City, town, or county) (State): Hanover Pa York Co

23. FUNERAL DIRECTOR'S SIGNATURE: Frederick Bucher — ADDRESS: Hanover Pa

24a. RECEIVED BY REGISTRAR DATE: JUN 5 '62 — 24b. REGISTRAR'S SIGNATURE: Arthur E. Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05645 Item 1c Film G315 6/28/62 iwk 05640

1. **PLACE OF DEATH**
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b: Since Dec. 29, 1961
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montg. Bethesda
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 1559.2
d. STREET ADDRESS 5901 Sonoma Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First Florence Middle Elgin Last Clark

4. **DATE OF DEATH**: Month 5 Day 29 Year 1962

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-22-88

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Clark

14. MOTHER'S MAIDEN NAME: Jenny Leibensperk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 287-05-0993

17. INFORMANT: Records of Springfield St. Hosp. Address

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Cardiac failure — 6 months
DUE TO (c): Arteriosclerosis general — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 334 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): C.B.S. with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, straet, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to May 29, 19 62 that (I) (we) last saw the deceased alive on May 29th 19 62, and that death occured at 9 p.m. from the causes and on the date stated above.

22a. SIGNATURE Myron Nizankowsky M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED 5-30-62

22c. PHYSICIAN'S NAME (Type) MYRON NIZANKOWSKY

22d. ADDRESS Springfield St. Hosp. Sykesville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit

23b. DATE THEREOF 5/31/62

23c. NAME OF CEMETERY OR CREMATORY Grove Hill Cemetery

23d. LOCATION (City, town or county) (State) Oil City, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REGISTRAR DATE: JUN 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05646 05641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 9-4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 9mos. 7 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clear Spring
   d. STREET ADDRESS: R#1
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Lola — Middle: May — Last: Thomas Davis

4. **DATE OF DEATH**: Month: May — Day: 17, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27, 1883

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elmer Carlton Thomas

14. MOTHER'S MAIDEN NAME: Cellie - LINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis. — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. with senile brain disease with psychotic reaction. Terminal Bronchopneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 10, 61, to May 17, 1962, that (I) (we) last saw the deceased alive on May 17, 19 62, and that death occured at 2:18 PM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

22b. DATE SIGNED: 5/17/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 5-17-62 — 23c. NAME OF CEMETERY OR CREMATORY: Boonsboro CEMETERY — 23d. LOCATION (City, town or county) (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: Bert Funeral Home — ADDRESS: Boonsboro MD.

25a. REC'D BY REGISTRAR DATE: MAY 22 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05647 — 05642 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1mo. 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 6
d. STREET ADDRESS: 14 E. Overlea Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Michael — Middle — Last Deluca
4. DATE OF DEATH: Month May — Day 2, — Year 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 2,1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Naturalized

13. FATHER'S NAME: Leopold Deluca
14. MOTHER'S MAIDEN NAME: MARY Concetta Caruso

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 219-32-0251A
17. INFORMANT — Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO (b): Arterio sclerotic Cardio — Several yrs

DUE TO (c): Renal disease

4427 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with circ.dist.,with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Unknown;was found unable to walk;x-ray revealed fracture neck of femur, left.
20c. TIME OF INJURY — Hour: 10:30 a.m. p.m. — Month, Day, Year: 4/21/19 62
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital
20f. (City or town): Sykesville (County): Carroll (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W. Glenn Speicher M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): W. GLENN SPEICHER Acting DEPUTY MEDICAL EXAMINER ☒ — 5/2/62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/5/62
22c. NAME OF CEMETERY OR CREMATORY: PARKWOOD Cem.
22d. LOCATION (City, town, or county): BALTIMORE (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: L. J. Ruck Inc. 5305 HARFORD Rd.
24a. REC'D BY REGISTRAR DATE: MAY 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05648

CERTIFICATE OF DEATH

05643

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M 15 I 0 1

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Sykesville
   c. LENGTH OF STAY IN 1b: 4 YR. 11 MO. 14 DA.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MD. — b. COUNTY: Frederick
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FREDERICK — 1011-2
   d. STREET ADDRESS: 116 East 3rd St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Helen — Middle: Violet — Last: Edmonds

4. **DATE OF DEATH**: Month: MAY — Day: 12, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-2-83

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rufus A. Ragger

14. MOTHER'S MAIDEN NAME: Susan Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Springfield Hospital records, Sykes. MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC FAILURE. INFECTED LARGE
715 X
DUE TO (b): BED SORE.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: DAYS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS. ASSO. WITH SENILE BRAIN DISEASE, WITH PSYCHOTIC REACTION.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JUNE 26, 1961 to MAY 12, 1962; that (I) (we) last saw the deceased alive on MAY 12, 1962, and that death occured at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunal M.D.

22b. DATE SIGNED: MAY 12, 1962

22c. PHYSICIAN'S NAME (Type): DR. NACI N. BUYUKUNAL

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Springfield State Hospital Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-15-1962

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert E. Dailey & Son

ADDRESS: Frederick, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 17 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05649

CERTIFICATE OF DEATH

05644

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 P

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
   c. LENGTH OF STAY IN 1b: 46y. 11m. 6d.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 1940 Lemmon Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 VOL 4

3. **NAME OF DECEASED** (Type or print): First: Helen; Middle:; Last: Eisler

4. **DATE OF DEATH**: Month: 5; Day: 27; Year: 19 62

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: unknown

9. AGE (In years last birthday): 81? yrs.
   IF UNDER 1 YEAR: Months: ; Days:
   IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? Hungary

13. FATHER'S NAME: Brichta?

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. **INFORMANT** Address: Springfield Hospital records - Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: days

300.7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, other and unspecified.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 6/21/ 19 15, to 5/27/ 19 62, that ☐ (we) last saw the deceased alive on 5/27/ 19 62, and that death occured at 12:20 AM from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/27/62

22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 30/62

23c. NAME OF CEMETERY OR CREMATORY: Oheb Sholom

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Sol Levinson & Bros Inc 6010 Reisterstown Rd

25a. REC'D BY REGISTRAR DATE: MAY 31 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05650

CERTIFICATE OF DEATH

05645
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 2½ Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 127 E. Green St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 06 X-1
d. STREET ADDRESS: 802 Belgian Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: (MARY ELLA) Middle: ELLA Last: FIELDS
4. DATE OF DEATH: Month: MAY Day: 28 Year: 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 19, 1871
9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife at Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hanson H. Keys
14. MOTHER'S MAIDEN NAME: Elizabeth Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
INFORMANT: Mrs J. Elmer Mauller — Address: 503 East Joppa Road Towson 4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs +
DUE TO (b): Arteriosclerosis (General) — 10 yrs +
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 59, to May 28, 1962, that I last saw the deceased alive on May 27, 1962, and that death occurred at 3:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Glenn Speicher M.D. — ADDRESS (Street, city or town, state): Westminster Md — DATE SIGNED: 5/28/62
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/30/62
22c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY
22d. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HENRY SANDER & SONS INC. BALTIMORE MD.
24a. REC'D BY REGISTRAR DATE: MAY 31 62
24b. REGISTRAR'S SIGNATURE: A. Elmer Straus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05651

CERTIFICATE OF DEATH

05646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 6mo.29days.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto. City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 6
   d. STREET ADDRESS: 6602 Fairdel Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Leona — Middle: Rita — Last: Fitch

4. **DATE OF DEATH**: Month: May — Day: 3, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan 26 1915

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Feliz Gabriel

14. MOTHER'S MAIDEN NAME: Susanna Stephens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 213-14-2801

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septicopyemia — Interval between onset and death: Weeks

453X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Gangrenous bedsores — Weeks

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. due to epidemic encephalitis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-31- 1961 to 5-3- 1962, that (I) (we) last saw the deceased alive on 5-3- 1962, and that death occured at 10:00 p.m. from the causes and on the date stated above.

22e. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-3-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/7/62

23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn

23d. LOCATION (City, town or county) (State): Baltimore - Md

24 FUNERAL DIRECTOR'S SIGNATURE: Carl B. Anderson — ADDRESS: Funeral Home 6306 - Belair Rd, - Baltimore 6, Md

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05652

CERTIFICATE OF DEATH

05647

Item 8 Film G313 5/23/62 iwk

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Taneytown
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Taneytown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	Harold	Francis	May	18	1962

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	[X] NEVER MARRIED [ ]	Nov. 5, 1878	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Horticulturist	Nursery	Liverpool, England	U.S.A.

13. FATHER'S NAME: Wallace F. Francis

14. MOTHER'S MAIDEN NAME: Sarah Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	077-15-6483	Mrs. Dencil E. Laird R#1, Taneytown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	Few Sec.
DUE TO (b)	Coronary Sclerosis	1 year
DUE TO (c)	Arteriosclerosis Generalized	10 yrs

420.1 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1957 to 5/18, 1962 that (I) (we) last saw the deceased alive on May 4 1962, and that death occured at 5A M, from the causes and on the date stated above.

22a. SIGNATURE: E. Ambler Thompson M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/18/62

22c. PHYSICIAN'S NAME (Type): E. Ambler Thompson

22d. ADDRESS: Taneytown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	5/22/62	Milford Cemetery	Milford, Connecticut

24 FUNERAL DIRECTOR'S SIGNATURE: Harold K. Stiles — ADDRESS: C.O. Fuss & Son, Taneytown, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 21 '62 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Hawn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05653

CERTIFICATE OF DEATH

05648

1. **PLACE OF DEATH**
a. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 10 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 54 LIBERTY ST.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WINFIELD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CORA Middle B. Last FRANKLIN

4. **DATE OF DEATH**: Month MAY Day 31 Year 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEB 23 - 1888

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES FRANKLIN

14. MOTHER'S MAIDEN NAME: CATHERINE FARVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. **INFORMANT**: MRS ADALENE SCHAEFFER Address: WESTMINSTER MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Several yrs
422.1
DUE TO (b): Arteriosclerosis (Gen'l)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 28, 1962 to May 31, 1962 that (I) (we) last saw the deceased alive on May 31, 1962, and that death occured at 9:45 AM, from the causes and on the date stated above.

22e. SIGNATURE: W Glenn Steicher
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/31/62
22c. PHYSICIAN'S NAME (Type): W GLENN STEICHER
22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6/2/62
23c. NAME OF CEMETERY OR CREMATORY: EBENEZER
23d. LOCATION (City, town or county): WINFIELD (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: D.D. Hartzler & Sons
ADDRESS: NEW WINDSOR MD

25a. REC'D BY REGISTRAR DATE JUN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05654

CERTIFICATE OF DEATH

05649

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

94

I

1. **PLACE OF DEATH** a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville #3 Md
c. LENGTH OF STAY IN 1b: 11 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pine Mill Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg RD#1
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. **NAME OF DECEASED** (Type or print): First GEORGE Middle LACKEY Last GASSMAN SR.

4. **DATE OF DEATH**: Month MAY Day 8 Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 10 1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Harrisonburg, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Gassman
14. MOTHER'S MAIDEN NAME: Ella Paul

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-34-5506
INFORMANT: Geo. L. Gassman Jr. Address: Maple Ave. Westminster Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
350X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from May, 1958 to May 5, 1962 that I last saw the deceased alive on May 5, 1962, and that death occurred at 5:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: R Reese Wilkens — ADDRESS (Street, city or town, state): 15 Kemperer — DATE SIGNED: 5/8/62

PHYSICIAN'S NAME (Type): F. REESE WILKENS — Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/11/62
22c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery
22d. LOCATION (City, town, or county) (State): Rural Westminster Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. E. Myers Jr. Westminster, Md.

24a. REC'D BY REGISTRAR DATE: MAY 14 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Shaw

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05655 05650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 1 month
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Howard
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenelg 13X-2
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Arthur — Middle: Franklin — Last: Gray

4. **DATE OF DEATH**: Month: May — Day: 15, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: August 10, 1884

9. AGE (In years last birthday): 77 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stewart W. Gray

14. MOTHER'S MAIDEN NAME: Maria -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Hours

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Thrombosis of the posterior left coronary artery. — Hours

DUE TO (c): Aspiration Pneumonia — Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with circ. dist., with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 16, 1962, to May 15, 1962 that (I) (we) last saw the deceased alive on May 14, 1962, and that death occured at 5:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 5/15/62

22c. PHYSICIAN'S NAME (Type): Adnan Sonmez, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 18,1962

23c. NAME OF CEMETERY OR CREMATORY: Laytonsville

23d. LOCATION (City, town or county) (State): Laytonsville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber

ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 21 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05656

CERTIFICATE OF DEATH

05651

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: -

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville

c. LENGTH OF STAY IN 1b: 2y. 4m. 22d.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01-4

15

d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: ? High Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frances Middle Julia Last Gray

4. DATE OF DEATH: Month 5 Day 15 Year 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/12/95

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Zack Owens

14. MOTHER'S MAIDEN NAME: Quade

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT Address: Springfield Hospital records - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours

420.1

Conditions, if any, which gave rise to immediate cause (o), stoting the underlying couse lost.

DUE TO (b): Coronary heart disease — years

DUE TO (c):

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Involutional Psychotic Reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 12/23 1959 to 5/15/ 1962, that ☒ (we) last saw the deceased olive on 5/15/ 1962, and that death occurred at 3:50 AM, from the causes and on the date stated above.

22a. SIGNATURE: Konstantin Weber M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/15/62

22c. PHYSICIAN'S NAME (Type): Konstantin Weber, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/18/62

23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart

23d. LOCATION (City, town, or county) (State): Buspwood Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. Clarke Mattingly, Leonardtown, Md

25a. RECD BY REGISTRAR DATE: MAY 21 62

25b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05657 05652

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural- Eldersburg
c. LENGTH OF STAY IN 1b: 1 ½ yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 10 Rolling View Drive

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Eldersburg
d. STREET ADDRESS: 10 Rolling View Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mr. Oscar — Middle: M — Last: Hackley

4. **DATE OF DEATH**: Month: May — Day: 19 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 1, 1902

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mechanical Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Locke Insulating Corp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles W. Hackley

14. MOTHER'S MAIDEN NAME: Jesse L. Kraut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-05-3092

17. INFORMANT: Mrs. Adelaide A. Hackley, Address: R.F.D. Box 313, Sykes-ville, Md. 10 Rolling View Dr.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Min.
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yaar 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 5/19/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/23/62

22c. NAME OF CEMETERY OR CREMATORY: Meadowridge Cemetery

22d. LOCATION (City, town, or country) (State): Baltimore 27, Maryland

23. FUNERAL DIRECTOR: Loring Byers — ADDRESS: 8728 Liberty Road, Randallstown, Md.

24a. REC'D BY REGISTRAR — DATE: MAY 23 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Keene

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05658

CERTIFICATE OF DEATH

05653
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION MILLS
c. LENGTH OF STAY IN 1b SEVERAL MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEADOW VIEW CONVALESCENT

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER
d. STREET ADDRESS 6 ANCHOR ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

90 M

3. NAME OF DECEASED (Type or print) First HARRY Middle WARNER Last HANDLEY
4. DATE OF DEATH Month MAY Day 16 Year 1962

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH FEB. 1 1885
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TARIFF CLERK
10b. KIND OF BUSINESS OR INDUSTRY CONSOLIDATION COAL Co.
11. BIRTHPLACE (State or foreign country) WESTMINSTER, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

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13. FATHER'S NAME JACOB H. HANDLEY
14. MOTHER'S MAIDEN NAME ANNA M. WARNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 256-07-1469
INFORMANT MISS FLOSSIE R. HANDLEY Address SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH 8 days
DUE TO (b) Arteriosclerosis — 10+ yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Had a stroke 2 1/2 yrs ago
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

1

21. I certify that I attended the deceased from June, 1962 to May 16, 1962 that I last saw the deceased alive on May 15, 1962, and that death occurred at 7:30 A M, from the causes and on the date stated above.
ACTUAL SIGNATURE M.D. R Reese Wilkens ADDRESS (Street, city or town, state) 15 Kemper ave DATE SIGNED 5/16/62
PHYSICIAN'S NAME (Type) DR. E. Reese WILKENS Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 5/19/62
22c. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY
22d. LOCATION (City, town, or county) (State) RURAL, WESTMINSTER, MD

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE MAY 21 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05659

CERTIFICATE OF DEATH

05654

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital Westminster Md

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millers (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: M. — Last: Harper

4. DATE OF DEATH: Month: May — Day: 4 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 4-4-93

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Andrew Smith

14. MOTHER'S MAIDEN NAME: Phoebe Vance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT Address: Paul Harper - Hampstead Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Hypertension — 2 0 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Cardio Vascular Disease — 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 1951, to May 4, 1962, that (I) (we) last saw the deceased alive on May 3 1962, and that death occured at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W N Foard M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/4/62

22c. PHYSICIAN'S NAME (Type): W N Foard M.D.

22d. ADDRESS: Manchester, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-6-62

23c. NAME OF CEMETERY OR CREMATORY: Manchester

23d. LOCATION (City, town or county) (State): Carroll Co. Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tipton - Eline - Hampstead Md

25a. REC'D BY REGISTRAR DATE MAY 7 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05660 Items 8 & 9 Film G314 6/1/62 mh 05655

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 14 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 8500 - 16th Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15 — 1526-2

3. **NAME OF DECEASED** (Type or print): First: Alice — Middle: - — Last: Kahn

4. **DATE OF DEATH**: Month: May — Day: 10, — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 16, ~~1896~~ 1897

9. AGE (In years last birthday): ~~65~~ 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No -

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Springfield Hospital Records

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MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
526X
DUE TO (b): Bronchiectasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Days / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus. C.B.S. associated with cerebral arteriosclerosis, with psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-26-, 1962, to 5-10-, 1962, that (I) (we) last saw the deceased alive on 5-10-62 19, and that death occured at 11:50 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-11-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 13, 1962

23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park

23d. LOCATION (City, town or county) (State): Falls Church, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Goodley Funeral Home — ADDRESS: 4217 9th Street N.W.

25a. REC'D BY REGISTRAR DATE MAY 14 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

Items 18&21 Film 515 6-28-62 ams

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05656

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Carroll Co. Gen. Hospital

c. LENGTH OF STAY IN 1b: 8 HOURS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland — b. COUNTY: Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Westminster

d. STREET ADDRESS: 1 56 Charles St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: LOVIE — Middle: [redacted] VIOLA — Last: KEY

4. DATE OF DEATH Month: May — Day: 10 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 23 - 1927

9. AGE (In years last birthday): 34 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CLARENCE HILL

14. MOTHER'S MAIDEN NAME: VIRGIE JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-20-8638

17. INFORMANT: THOMAS KEY SR — Address: WESTMINSTER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Amniotic fluid embolism

648.3

DUE TO (b): Recent Pregnancy

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

2

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: May 11, 1962

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

Address (Street, city, town, or county)

2

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/13/62

22c. NAME OF CEMETERY OR CREMATORY: MT OLIVE

22d. LOCATION (City, town, or country) (State): FREDERICK CO MD

23. FUNERAL DIRECTOR: D D Hartzler + Sons — ADDRESS: New Windsor

24a. REC'D BY REGISTRAR: DATE MAY 1 4 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS. A15ME 5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05662

05657

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 26 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 WESTMINSTER
d. STREET ADDRESS: 141 WESTMORELAND ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ESTELLA — Middle: MAY — Last: KROH

4. DATE OF DEATH: Month: MAY — Day: 18 — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 11, 1883

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EPHRAIM BACHMAN

14. MOTHER'S MAIDEN NAME: CORNELIA WENTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

INFORMANT: DAUGHTER - CORNELIA KROH — Address: 41 WESTMORELAND ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CANCER OF LEFT BREAST
170 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL, 1958, to MAY 18, 1962 that I last saw the deceased alive on MAY 18, 1962 and that death occurred at 11:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William Lewis Stewart, M.D.

ADDRESS (Street, city or town, state): 19 RIDGE RD

DATE SIGNED: 5/18/62

PHYSICIAN'S NAME (Type): WESTMINSTER, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/21/62

22c. NAME OF CEMETERY OR CREMATORY: John L. Miller Cemetery

22d. LOCATION (City, town, or county) (State): Rural, Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, Jr.

ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: MAY 22 '62

24b. REGISTRAR'S SIGNATURE: Evelyn S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05663

CERTIFICATE OF DEATH

05658

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 4yrs.2mos.4dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 1128 Chesthaven Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Florence — Middle: Lillian — Last: Lewis

4. **DATE OF DEATH**: Month: May — Day: 14 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 21, 1885

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - Own home

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nathan ~~De-Lavergene-~~ DeLaVergne

14. MOTHER'S MAIDEN NAME: Anna C. -Claudine Thomson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No - none

16. SOCIAL SECURITY NO.: - none

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Bilateral lobular pneumonia, type undetermined. — INTERVAL BETWEEN ONSET AND DEATH: Days

490X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychotic depressive reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 10, 1958, to May 14, 1962, that (I) (we) last saw the deceased alive on May 14, 1962, and that death occured at 10 pm, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-14-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-18-62

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisk ADDRESS: 8454 Georgia Avenue

Warner E. Pumphrey, Inc., Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 17 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05664

CERTIFICATE OF DEATH

05659

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sunbord Rural
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sunbord (Rural)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle T — Last LOVELL

4. DATE OF DEATH: Month May — Day 31 — Year 1962

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	MARRIED ☒	Aug 14-1888	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Farm	Maryland	U S A

13. FATHER'S NAME: Thomas W Lovell

14. MOTHER'S MAIDEN NAME: Emma Malonell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-22-1530

17. INFORMANT: Mrs Minnie E Lovell — Address: Sunbord Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
332 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 28, 1962, to May 30, 1962, that (I) (we) last saw the deceased alive on May 30 19 62, and that death occured at 4 a.m. from the causes and on the date stated above.

22a. SIGNATURE: M. C. Porterfield, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): M.C.Porterfield

22d. ADDRESS: Hampstead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 2/62 — 23c. NAME OF CEMETERY OR CREMATORY: Sunebord — 23d. LOCATION (City, town or county) (State): Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: Tipton-Elmo — ADDRESS: Hampstead Md

25a. REC'D BY REGISTRAR DATE: JUN 4 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Hawn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05665 05660

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 1 — 3 V 01 . 4
d. STREET ADDRESS: 409 Park Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hugh — Middle: James — Last: Martin, Jr.

4. DATE OF DEATH: Month: May — Day: 31, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 23,1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hugh J. Martin, Sr.

14. MOTHER'S MAIDEN NAME: Ellen Keefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 1918-1919- Army #3074877

16. SOCIAL SECURITY NO.: 578-05-7232A

17. INFORMANT — Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — Days
DUE TO (b): C.V.A. with complete paralysis of the left side — Days
DUE TO (c):

331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 10, 19 62 to May 31, 19 62 that (I) (we) last saw the deceased alive on May 30, 19 62, and that death occured at 6 AM, from the causes and on the date stated above.

22a. SIGNATURE: Adnan Sonmez M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/31/62

22c. PHYSICIAN'S NAME (Type): Adnan Sonmez, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-4-62

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Frederick Ave, Balto. Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Luther A. Haight Sykesville, Md.

25a. REC'D BY REGISTRAR DATE JUN 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kunz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05666

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05661

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural- Mt. Airy
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RFD # 2

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Mt. Airy
   d. STREET ADDRESS: RFD # 2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Daniel — Middle: Eugene — Last: Mayne

4. **DATE OF DEATH**: Month: May — Day: 17 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 30, 1956

9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frederick, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert M. Mayne

14. MOTHER'S MAIDEN NAME: Shirley A. Cooley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs Robert M. Mayne, Item 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broken neck — INTERVAL BETWEEN ONSET AND DEATH: Mi

835 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Tractor accident — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Tractor upset on him

20c. TIME OF INJURY — Hour a.m.: 9 — Month, Day, Year: 5/17/62

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town): Rt 2 Mt Airy — (County): Carroll — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county):

DATE SIGNED: 5/17/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 20, 1962

22c. NAME OF CEMETERY OR CREMATORY: Jennings Chapel

22d. LOCATION (City, town, or country) (State): Florence, Md.

23. FUNERAL DIRECTOR: Olin L. Molesworth — ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR — DATE: MAY 21 '62

24b. REGISTRAR'S SIGNATURE: Clarence L. Hawes

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05667

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05662

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester (Rural)
   c. LENGTH OF STAY IN 1b: 10 Yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester (Rural)
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALFRED Middle S Last MAYS

4. DATE OF DEATH: Month May Day 4 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-1-1888

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Mays

14. MOTHER'S MAIDEN NAME: Martha Shearer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Blanch Mays Address: Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gunshot wound of chest — INTERVAL BETWEEN ONSET AND DEATH: Min.

976X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted gunshot

20c. TIME OF INJURY: Hour 8 a.m. p.m. Month, Day, Year 5/4 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Manchester (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Marsh M.D.

EXAMINER'S NAME (Type): JAMES I. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 5/4/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 7-62

22c. NAME OF CEMETERY OR CREMATORY: St Peters

22d. LOCATION (City, town, or country): Balto Co (State) Md

23. FUNERAL DIRECTOR: Tipton-Cline ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: MAY 7 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05668

05663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GIST
c. LENGTH OF STAY IN 1b: 11 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: P.O. R.D.3 Sykesville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Carroll
c. CITY OR TOWN (If outside carporote limits, write RURAL ond give nearest town): XGIST
d. STREET ADDRESS: P.O. Sykesville. R.D.3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First THOMAS Middle 2. Last McKENZIE

4. DATE OF DEATH: Month 5 Day 9 Year 62 19

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: November 6, 1874
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Mill. Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ZACARIAH McKENZIE
14. MOTHER'S MAIDEN NAME: MARGARET DURST

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address: Mr. GRANT H. McKenzie, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis (chr) — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): Syphilis (Chr) — ?
DUE TO (c): Flu — Few days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Part I ar Part II af item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 59, to May 9, 19 62, that I last saw the deceased alive on 5-8-, 19 62, and that death occurred at 7:11 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W.C. Kennette M.D. — ADDRESS (Street, city or town, state): 103 E Main Westminster Md — DATE SIGNED: 5-10-62
PHYSICIAN'S NAME (Type): W.C. KENNETTE M.D. — 103 E MAIN WESTMINSTER Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May-12, 1962
22c. NAME OF CEMETERY OR CREMATORY: St. Anns. Cemetery
22d. LOCATION (City, town, or county) (State): Aviton, Carroll Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: C.M. Waltz, Box 241 Sykesville, Md.
24a. REC'D BY REGISTRAR DATE: MAY 14 '62
24b. REGISTRAR'S SIGNATURE: Clifford L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05669

CERTIFICATE OF DEATH

05664

1. PLACE OF DEATH
a. COUNTY: ~~Balti~~ Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore ~~Carroll~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Timonium
d. STREET ADDRESS: 2044 York Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

03x-2

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Elsworth	Merryman, Sr.	May	8,	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White		April 28, 1899	63 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Radio Broadcastin	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Lewis Elsworth Merryman	Margaret Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No -	215-03-9326	Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute peritonitis
163 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Perforated gastric ulcers
DUE TO (c): Carcinoma of the right lung with metastasis to the third thoracic vertebra.

INTERVAL BETWEEN ONSET AND DEATH: Days / Weeks / Months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. due to arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 20, 1962 to May 8, 1962, that (I) (we) last saw the deceased alive on May 8, 1962, and that death occured at 10 AM from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Adnan Sonmez M.D.		5/8/62

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Adnan Sonmez, M.D.	Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	5-11-62	St. Joseph's Catholic	Cockeysville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Brooks Funeral Service, Inc, Towson 4 Md	MAY 14 '62	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05665

1. PLACE OF DEATH — a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE RURAL
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X UNION BRIDGE RURAL
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES — Middle ULRICH — Last MESSLER

4. DATE OF DEATH: Month MAY — Day 6 — Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MAR 9- 1888

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR — Months — Days
IF UNDER 24 HRS. — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LOUIS U MESSLER

14. MOTHER'S MAIDEN NAME: ANNIE ROWE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-22-9694

17. INFORMANT — Address: CLARA MESSLER UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Indefin
DUE TO
420.1
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 6 19 62 to May 6 19 62 that (I) (we) last saw the deceased alive on May 6 19 62 and that death occurred at 2:10 P. M. from the causes and on the date stated above.

22a. SIGNATURE: J. H. Messler M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: May 7, 1962

22c. PHYSICIAN'S NAME (Type): J. H MESSLER, M. D.

22d. ADDRESS: UNION BRIDGE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 8- 1962

23c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK

23d. LOCATION (City, town, or county) (State): CARROLL CO MD

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: D D Hartzler & Sons Union Bridge

25a. REC'D BY REGISTRAR DATE: MAY 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05671

CERTIFICATE OF DEATH

05666
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL. SYKESVILLE, MD.
c. LENGTH OF STAY IN 1b: 3 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOX 140 ARTHUR AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SYKESVILLE, MD.
d. STREET ADDRESS: BOX #140 ARTHUR AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle EDWARD Last MITCHELL

4. DATE OF DEATH: Month MAY Day 17, Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 23, 1891

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FINISHER-CEMENT

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM E. MITCHELL

14. MOTHER'S MAIDEN NAME: SARAH C. COLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-01-2885

INFORMANT: MRS. CHARLES MITCHELL, WIFE
Address: ARTHUR AVE, SYKESVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension - general
DUE TO (c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Silicosis - Worked in cement & dust

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-2-62 to 5-17-62, that I last saw the deceased alive on 5-16-62, and that death occurred at 7:15 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James G. Saffell M.D. ADDRESS (Street, city or town, state): Reisterstown, Md. DATE SIGNED: 5-18-62

PHYSICIAN'S NAME (Type): James G. Saffell MD. Reisterstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/21/62

22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVE CEMETERY

22d. LOCATION (City, town, or county) (State): RANDALLSTOWN, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: James G. Saffell Jr. ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: MAY 21 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05672 — Item 9 Film 0314, 6/11/62 mh — 05667

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.1mo.28dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceasad lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18 3V01.4
d. STREET ADDRESS: 2614 N. Charles Stret
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ethel	Marie	Mitchell	May	29,	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		September 29, 1899	61 62 rs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife/odd jobs	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robinson	Helen -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No -	-	Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: Years

527.1

Conditions, if any, which gave rise to immedieta cause (a), stating the underlying cause last.

DUE TO (b): Chronic obstructive pulmonary emphysemia and fibrosis — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from April 1, 1960 to May 29, 1962, that (I) (we) last saw the deceased alive on May 29, 1962, and that death occured at 3:30 p.m. from the causes and on the date stated above.

22e. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-29-62
22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	6/5/62	Beverly National Cemetery	Beverly, New Jersey

24 FUNERAL DIRECTOR'S SIGNATURE: Ellsworth Armacost — ADDRESS: Ellsworth Armacost-4600 Liberty Hghts. Ave

25e. REC'D BY REGISTRAR DATE JUN 1 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur J. Krug

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05668

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - Westminster
   c. LENGTH OF STAY IN 1b: 37 Years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Westminster, R. D. 7

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Westminster
   d. STREET ADDRESS: Westminster, R. D. 7
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Gruver — Middle: J. — Last: Morelock

4. DATE OF DEATH: Month: 5/15/62 — Day — Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 10/18/1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: His own farm

11. BIRTHPLACE (State or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Milton Morelock

14. MOTHER'S MAIDEN NAME: Susan Reinecker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. — (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 219-36-0290

17. INFORMANT — Address: Mrs. Bertie Morelock, Westminster, Md. R.D.7

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing injury to chest — INTERVAL BETWEEN ONSET AND DEATH: 20 min (?)
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
9/2.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Tractor accident

20c. TIME OF INJURY: Hour: 1145 a.m. — Month, Day, Year: 5/15 1962

20d. INJURY OCCURRED While at work [X] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm Rd

20f. (City or town): Westminster (County): Carroll (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county): Forest Co Md

DATE SIGNED: 5/15/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 5/18/62

22c. NAME OF CEMETERY OR CREMATORY: Baust Church Cemetery

22d. LOCATION (City, town, or country) (State): Nr. Taneytown, Carroll Co., Md.

23. FUNERAL DIRECTOR: Richard A Little — ADDRESS: Littlestown, Pa.

24a. REC'D BY REGISTRAR — DATE: MAY 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05674 — 05669

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b: 10 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CRANBERRY RD at ROUTE 140

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 18 NEW WINDSOR RD 27
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GALEN Middle FRANKLIN Last MYERS

4. DATE OF DEATH: Month MAY Day 9 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 9 1906

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinists Helper

10b. KIND OF BUSINESS OR INDUSTRY: Western Md. R.R.

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD J. MYERS

14. MOTHER'S MAIDEN NAME: ELLA MYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) ___ (If yes give war or dates of service) ___

16. SOCIAL SECURITY NO.: 705-12-5426

17. INFORMANT: Mrs Galen F. Myers, Address Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound chest
976X
DUE TO (b): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ___
INTERVAL BETWEEN ONSET AND DEATH: ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted

20c. TIME OF INJURY: 1:30 e.m. Month, Day, Year 5/9 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Off Route 140

20f. (City or town) Uniontown (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: James T Marsh M.D.

EXAMINER'S NAME (Type): JAMES T MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): ___

DATE SIGNED: 5/10/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/12/62

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem. Gardens

22d. LOCATION (City, town, or country) Finksburg (State) Md

23. FUNERAL DIRECTOR: J. L. Myers, Jr. ADDRESS: Westminster, Md

24a. REC'D BY REGISTRAR: DATE MAY 14 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

1

FOR STATE HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05675 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05670

Item 8 Film G313 5/23/62 iwk

1. PLACE OF DEATH
a. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER RD #4
c. LENGTH OF STAY IN 1b: 5 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER RD #4
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First EARL Middle WOODROW Last NONEMAKER

4. DATE OF DEATH: Month MAY Day 16 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 5, 1917 1918

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CARROLL CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHESTER NONEMAKER

14. MOTHER'S MAIDEN NAME: CORA Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): WORLD WAR II

16. SOCIAL SECURITY NO.: 183-14-8429

17. INFORMANT: MRS. EARL W. NONEMAKER
Address: SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound Heart
976X
DUE TO (b): Self Inflicted
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher acting M.D.
EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 5/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 19 1962

22c. NAME OF CEMETERY OR CREMATORY: St Jacobs (Manor) Church

22d. LOCATION (City, town, or country): Bradbeck RD (State): Po Pa.

23. FUNERAL DIRECTOR: H. R. Seiffa
ADDRESS: Glen Rock Po PA.

24a. REC'D BY REGISTRAR DATE: MAY 18 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05676 — Item 3 Film G314 6/5/62 iwk — 05671

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: CARROLL — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural, Sykesville
   c. LENGTH OF STAY IN 1b: 14 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   e. STATE: Maryland — b. COUNTY: City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City (6) 3 Vol 4
   d. STREET ADDRESS: 5418 Remmel Avenue
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First Oberender, Middle Harry Henry, Last V

4. **DATE OF DEATH**: Month 5 — Day 22 — Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 3-6-1874

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): sign painter (retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Oberender (deceased

14. MOTHER'S MAIDEN NAME: Margaret Hoffman (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Hospital records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

DUE TO (b): Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome associated with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/8 19 62 7:45AM to 5/22, 19 62, that (I) (we) last saw the deceased alive on 5/22 19 62, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Gertrude M. Gross, M.D. M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/22/62

22c. PHYSICIAN'S NAME (Type): Gertrude M. Gross, M. D.

22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/25/62

23c. NAME OF CEMETERY OR CREMATORY: PARKWOOD Cem.

23d. LOCATION (City, town or county) (State): BALTIMORE Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: L. J. Ruck Inc 5305 HARFORD Rd.

25a. REC'D BY REGISTRAR DATE: MAY 25 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Kiracofe

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05677 — 05672

TO HOLD BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 1 mo. 26 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 21032
   d. STREET ADDRESS: 278 S. Prospect St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Philip — Middle: Leo — Last: Reardon

4. **DATE OF DEATH**: Month: May — Day: 28, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 27, 1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sup't., Insurance Co.

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Reardon

14. MOTHER'S MAIDEN NAME: Julia McMannis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Interstitial pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: Days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Recurrent C.V.A. — Weeks

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 2, 1962, to May 28, 1962 that (I) (we) last saw the deceased alive on May 28, 1962, and that death occured 10:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Adnan Sonmez M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/29/62

22c. PHYSICIAN'S NAME (Type): Adnan Sonmez, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-1-62

23c. NAME OF CEMETERY OR CREMATORY: REST HAVEN CEMETERY

23d. LOCATION (City, town or county) (State): HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Edward M. Rouzer

ADDRESS: SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE JUN 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05678 — Items 2 & 8 Film G312 5/14/62 mh — 05673

1 (M) 15 1 2 1

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 10 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Maryland~~ New Jersey — b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Rockville~~ Somerville — 6 7 X 3
d. STREET ADDRESS: 39 Third St. ~~Tyson Nursing Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rodgers — Middle: Sadie Dorothy Raymond — Last: ~~Rogers~~

4. DATE OF DEATH: Month: 5 — Day: 4 — Year: 19 62

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	WIDOWED ☒	7/27/71	90 ~~89~~ yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Mass., U.S.A.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Bernard Raymond	Sophia Raymond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Hosp. records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: days

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. ass. with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/3/61, 19..., to 5/4/62, 19..., that (I) (we) last saw the deceased alive on 5/4 19 62, and that death occured at 5 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5/5/62

22c. PHYSICIAN'S NAME (Type): Agustine delCampo — 22d. ADDRESS: Springfield State Hosp

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Cremation	5/7/1962	Lee	Washington D.C.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Luther Haight	Sykesville, Md.	MAY 9 '62	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05679

CERTIFICATE OF DEATH

05674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 7yrs 5Mos.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3V01.4
   d. STREET ADDRESS: 2921 Kirk Ave.
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): (First) Henry (Middle) Andrew (Last) Rohrbach (HENRY ANDREW ROHRBACH SR.)

4. **DATE OF DEATH**: Month: May; Day: 20; Year: 1962

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 11, 1892

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grand - Govt Postal

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Frederick Rohrbach

14. MOTHER'S MAIDEN NAME: Mary Schwicher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): World War I

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Henry Rohrbach, Jr. Address: 6013 Belle Vista Ave. Balto. 6, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis — yrs.

DUE TO (c): (Involutional psychotic Reaction, plus — about 7 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Decubitus ulcer, multiple

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept., 1960 to May, 1962, that (I) (we) last saw the deceased alive on May 20 1962, and that death occured at 4A.M, from the causes and on the date stated above.

22a. SIGNATURE: Yasuo Takahashi M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: May 20, 1962

22c. PHYSICIAN'S NAME (Type): YASUO TAKAHASHI

22d. ADDRESS: SPRINGFIELD STATE HOSPITAL, MD. SYKESVILLE

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 23, 1962

23c. NAME OF CEMETERY OR CREMATORY: WOODLAWN CEMETERY

23d. LOCATION (City, town or county) (State): WOODLAWN MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HENRY SANDER & SONS INC. BALTIMORE MD.

25a. REC'D BY REGISTRAR DATE: MAY 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05680

CERTIFICATE OF DEATH

05675

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD #1-Box 298-Liberty Road

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sykesville
d. STREET ADDRESS: RFD #1-Box 298-Liberty Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: August — Middle: H. — Last: Rohm

4. **DATE OF DEATH**: Month: May — Day: 15 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 25, 1880

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heating Contractor (self)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leonard Rohm

14. MOTHER'S MAIDEN NAME: Margaret Hutzler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-9557

INFORMANT Address: Mrs. Elsie M. Rohm-FRD #1-Box 298-Liberty Road

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs

443X

DUE TO (b): General Arteriosclerosis — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Senile Changes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 1935, 19___, to 15 May, 1962, 19___, that I last saw the deceased alive on 15 May, 1962, 19___, and that death occurred at 6:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm H Lawson M.D.

ADDRESS (Street, city or town, state): Box 54 RFD#2, Sykesville, Md

DATE SIGNED: 5/15/62

PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-18-62

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Wm J Tuckner & Sons Mt Pa Ave Balto 17, Md.

24a. REC'D BY REGISTRAR DATE: MAY 16 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

2 12

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05681 05676

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

M X I 0 2

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
   c. LENGTH OF STAY IN 1b: 10 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hampstead
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First ROSEMARY — Middle A — Last RUBY

4. **DATE OF DEATH**: Month May Day 14 Year 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr 23 1932

9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator

10b. KIND OF BUSINESS OR INDUSTRY: Sew Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Patrick Brady

14. MOTHER'S MAIDEN NAME: Virginia Hipple

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or data of service): No

16. SOCIAL SECURITY NO.: 217-28-6129

17. INFORMANT: Russell Ruby — Address: Hampstead Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e): Gunshot wound of head.
DUE TO (b):
DUE TO (c):

976X

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gun shot wound

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 5/14 1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hampstead (County) Carroll (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 5/14/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 17/62

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Gardens

22d. LOCATION (City, town, or country) Carroll Co (State) Md

23. FUNERAL DIRECTOR: Upton-Eline — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: MAY 17 '62

24b. REGISTRAR'S SIGNATURE: Clifton L. Timms

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05682

CERTIFICATE OF DEATH

05677

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Union Bridge
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Middleburg

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Run
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle PAULINE Last SCHAEFFER

4. DATE OF DEATH: Month MAY Day 28 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 13 1891
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Un-employed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Silver Run Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Schaeffer
14. MOTHER'S MAIDEN NAME: Mary C. Feiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mrs. Theo. F. Brown, Address Penna. Ave. Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Carcinoma of the breast
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170 X

INTERVAL BETWEEN ONSET AND DEATH: ? 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/27/62 19___ to 5/28/62 19___, that (I) (~~we~~) last saw the deceased alive on 5/28/62 19___, and that death occurred at 6A M, from the causes and on the date stated above.

22a. SIGNATURE: J. H. Carcofa M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/28/62
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Union Bridge, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/31/62
23c. NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery
23d. LOCATION (City, town, or county) (State): Rural Westminster Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. S. Myers, Jr. Westminster, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE MAY 31 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05683

CERTIFICATE OF DEATH

05678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 6 mos./12 das.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: -
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore #2 3V01-4
   d. STREET ADDRESS: 20 S. Ellwood Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Karl — Middle: Ludwig — Last: SR. SCHARPF

4. **DATE OF DEATH**: Month: May — Day: 19, — Year: 19 62

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-30-1883

9. AGE (In years last birthday): 78 68 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): baker

10b. KIND OF BUSINESS OR INDUSTRY: Koester's Bakery

11. BIRTHPLACE (County & State, or foreign country): Germany unknown

12. CITIZEN OF WHAT COUNTRY? USA ?

13. FATHER'S NAME: ? Scharpf

14. MOTHER'S MAIDEN NAME: Dorothy ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: 212-10-6699

17. INFORMANT — Address: Springfield State Hospital Records

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO (b): Bronchopneumonia, recurrent
DUE TO (c): A.S.C.V.D.

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: days / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. & Senile brain disease & psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-7-61, 19, to 5/19, 1962., that (I) (we) last saw the deceased alive on 5/19/62 19, and that death occured at 9 pM, from the causes and on the date stated above.

22a. SIGNATURE: Adnon Sonmez M.D. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/19/62

22c. PHYSICIAN'S NAME (Type): Adnon Sonmez, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 23, 1962

23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John A. Moran

ADDRESS: 3000 E. Baltimore St

25a. REC'D BY REGISTRAR DATE: MAY 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

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FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05684

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05679

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead Rural
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hampstead Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JACKIE-LEE — Middle — Last SCHOONOVER

4. DATE OF DEATH: Month May — Day 19 — Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-21-1955

9. AGE (In years last birthday): 6 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Schoonover

14. MOTHER'S MAIDEN NAME: Patricia Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Richard Schoonover — Address: Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DROWNING

929.8

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year: 10:30 a.m. 5-19 1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Cascade Lane

20f. (City or town) (County) (State): HAMPSTEAD CARROLL MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): JAMES T MARSH

Address (Street, city, town, or county):

DATE SIGNED: 5/19/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-22-62

22c. NAME OF CEMETERY OR CREMATORY: Johnsville Cem

22d. LOCATION (City, town, or country) (State): Frederick Co Md

23. FUNERAL DIRECTOR: Tipton-Eline — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: MAY 23 '62

24b. REGISTRAR'S SIGNATURE: Christine S. Krause

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05685

CERTIFICATE OF DEATH

05680 Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER
c. LENGTH OF STAY IN 1b: 8 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 59 WASHINGTON, RD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XRURAL WESTMINSTER
d. STREET ADDRESS: 59 WASHINGTON ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle BERNARD Last SHAEFFER

4. DATE OF DEATH: Month MAY Day 31 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 16, 1898

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED, SALES ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY: RAUSTINE CO PERRY, N.Y.

11. BIRTHPLACE (State or foreign country): WESTMINSTER, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY K. SHAEFFER

14. MOTHER'S MAIDEN NAME: MARY S. ECKENRODE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-05-4396

INFORMANT: MRS. ADELINE T. SHAEFFER Address: SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTIC CA of BLADDER to LUNGS.
154X
DUE TO (b): CA. of RECTUM
DUE TO (c):

Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.

INTERVAL BETWEEN ONSET AND DEATH: (a) MONTHS. (b) 24 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from MAR 1 1962, to MAY 31 1962, that I last saw the deceased alive on MAY 31 1962, and that death occurred at 2:30 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James T. Marsh M.D.
ADDRESS (Street, city or town, state): 105 E Main St. Westminster Md
DATE SIGNED: 6-1-62

PHYSICIAN'S NAME (Type): JAMES T MARSH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/4/62
22c. NAME OF CEMETERY OR CREMATORY: KRIDERS CEMETERY
22d. LOCATION (City, town, or county) (State): RURAL, WESTMINSTER, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr.
ADDRESS: Westminster, Md.

24a. REC'D BY REGISTRAR DATE: JUN 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur E. Roma

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05686

CERTIFICATE OF DEATH

05681

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Grand View Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown 03x-2
d. STREET ADDRESS: Chatsworth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harry — Middle: H. — Last: Shaffer

4. DATE OF DEATH: Month: May — Day: 17 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 13, 1877

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John D. Shaffer

14. MOTHER'S MAIDEN NAME: Lydia E. Arbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 212-32-4434

17. INFORMANT Address: H. Stewart Shaffer, Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis, arteriosclerotic

420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): heart dis, arteriosclerosis gen.

DUE TO (c): already.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr — 17 May 62

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19..., to 17 May, 19 62, that (I) (we) last saw the deceased alive on 17 May 19 62, and that death occured at 5:P M, from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 18 May 62

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Jefferville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 21, 1962

23c. NAME OF CEMETERY OR CREMATORY: Kriders

23d. LOCATION (City, town or county) (State): Westminster, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J.F. Eline & Sons, Reisterstown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 21 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HAVE MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05687

CERTIFICATE OF DEATH

05682

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11 WARD AVE

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 WESTMINSTER
d. STREET ADDRESS: 11 WARD AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CECELIA — Middle: ELIZABETH — Last: SKINNER

4. DATE OF DEATH: Month: MAY — Day: 18 — Year: 1962

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W	WIDOWED ☒	APRIL 29- 1893	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	OWN HOME	MARYLAND	USA

13. FATHER'S NAME: HENRY C DANNER

14. MOTHER'S MAIDEN NAME: CORA SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	339-07-9576	MRS MONROE HYDE	NEW WINDSOR RURAL MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

260 X

DUE TO (b): Arteriosclerotic Cardio Vascular disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Diabetes Mellitus — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — **20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — **20d.** INJURY OCCURRED While at work ☐ Not While at work ☐ — **20e.** PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..., 1955, to May 18, 1962 that (I) (we) last saw the deceased alive on May 12 1962, and that death occured at 9 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James T Marsh M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — **22b.** DATE SIGNED: 5-18-62

22c. PHYSICIAN'S NAME (Type): JAMES T MARSH — **22d.** ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	5/21/62	WINTERS	NEW WINDSOR RURAL MD

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
D D Hartzler & Sons	New Windsor	DATE MAY 22 '62	Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05688 — 05683

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CARROLL COUNTY GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X UNION BRIDGE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MAY Last STAMBAUGH

4. DATE OF DEATH: Month MAY Day 1 Year 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV 2 - 1872
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: W. NELSON WILLHIDE
14. MOTHER'S MAIDEN NAME: MAGDALENE GRAHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: W. E. STAMBAUGH Address: UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Arterio Sclerotic C.V. disease — 4 years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/29/62 19__ to 5/1/62 19__, that (I) (we) last saw the deceased alive on 4/30/62 19__, and that death occurred at 1:15 PM from the causes and on the date stated above.

22a. SIGNATURE: James T Marsh M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/1/62
22c. PHYSICIAN'S NAME (Type): JAMES T. MARSH
22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 4-62
23c. NAME OF CEMETERY OR CREMATORY: UNITED BRETHREN
23d. LOCATION (City, town, or county) (State): THURMONT, MD.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: O. O. Hartlet Sons UNION BRIDGE MD
25a. REC'D BY REGISTRAR DATE: MAY 7 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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FOR STATE HEALTH DEPT.

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TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

05689

Bureau of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05684

1. PLACE OF DEATH
a. COUNTY: CARROLL CO. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAMBER, MD.
c. LENGTH OF STAY IN 1b: 11 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): AT FORD'S STORE. GAMBER, MD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GAMBER, MD.
d. STREET ADDRESS: FINKSBORG RD #1, MD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle JOSEPH Last STECK

4. DATE OF DEATH: Month MAY Day 23 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/11/1914

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): MISSISSIPPI

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH STECK

14. MOTHER'S MAIDEN NAME: BALBINA TOMCUK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES
(If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 215-03-2709

17. INFORMANT: WIFE MRS. FRANK STECK Address: FINKSBURG RD #1, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): ___
DUE TO (c): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wilson Speicher M.D. acting
EXAMINER'S NAME (Type): CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: May 23-1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL.
22b. DATE THEREOF: 5/26/1962
22c. NAME OF CEMETERY OR CREMATORY: PROVIDENCE CEMETERY
22d. LOCATION (City, town, or country) (State): GAMBER, MD.

23. FUNERAL DIRECTOR: James D. Saffell Jr. ADDRESS: 254 E. MAIN ST. WESTMINSTER MD

24a. REC'D BY REGISTRAR DATE: MAY 28 '62
24b. REGISTRAR'S SIGNATURE: Charles L. Thomas

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05690

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05685

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 2 mo +
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. Gen. Hospt.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   d. STREET ADDRESS: 70 Liberty St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARY Middle ELIZABETH Last STOECKER

4. **DATE OF DEATH**: Month MAY Day 28 Year 1962

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 28 1869
9. AGE (In years last birthday): 93 yrs.
   IF UNDER 1 YEAR: Months ____ Days ____
   IF UNDER 24 HRS.: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home-wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Westminster Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob T. Thmsen
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
    (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. John Case, Address: Same address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio sclerotic cardio renal disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture of right hip — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell in bedroom
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 3-1 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Westminster (County): Carroll (State): Md

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): JAMES T MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 5/28/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/31/62
22c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
22d. LOCATION (City, town, or country): Westminster (State): Md.

23. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr. / Westminster, Md.

24a. REC'D BY REGISTRAR DATE: MAY 31 '62
24b. REGISTRAR'S SIGNATURE: Carlton L. Frank

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05691

05686

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(M)

15

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2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery ✓
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Rural - Sykesville	c. LENGTH OF STAY IN 1b: 2yr.3mo.6da.
c. CITY OR TOWN (If outside carporote limils, write RURAL ond give nearest town): Kensington 1536.2	
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital	d. STREET ADDRESS: 10515 Meredith Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Yeor
Anne	Lurie	STOLZENBACH	MAY	4	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		4-28-81	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Fairweather	Genevieve Densmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (o), (b), ond (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o): Heart Block — INTERVAL BETWEEN ONSET AND DEATH: Weeks

4221

Conditions, if any, which gove rise to immediote couse (o), stoting the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular Disease — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): CBS with Circulatory Disturbance, with psychotic reaction. — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from 1-28, 1960, to 5-4, 1962, that ~~I~~ (we) last saw the deceased alive on 5-4-1962, and that death occurred at 4:25 M, from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Ilse Kamm M.D.		5-4-62
22c. PHYSICIAN'S NAME (Type): Ilse Kamm, M. D.	22d. ADDRESS: Sykesville, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Cremation	5/7/1962	Lee's	Washington D.C.

24a. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee Funeral Home	300 - 4 St Wash D.C.	MAY 9 '62	Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05692

CERTIFICATE OF DEATH

05687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 11 mo. 2dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto. City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 1 — 3V01-4
   d. STREET ADDRESS: 1818 N. Charles St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Edith — Middle: Irene — Last: Trail

4. **DATE OF DEATH**: Month: May — Day: 25, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 20, 1883

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James H. Collette

14. MOTHER'S MAIDEN NAME: Emma Irwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital records.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Years

420.1

DUE TO (b): Severe coronary arteriosclerosis — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Pulmonary edema and early bronchopneumonia — Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 23, 1961, to May 25, 1962, that (I) (we) last saw the deceased alive on May 25, 1962, and that death occured at 4:50 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-25-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-28-62

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Hampden

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J Tokner & Sons

ADDRESS: Balto 12, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 28 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05693

CERTIFICATE OF DEATH

05688

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

1 (M) 68 I

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 2 Days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll County General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Westminster
   d. STREET ADDRESS: 1 Westminster, Md. R. D. 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ida — Middle: Louise — Last: Utz

4. **DATE OF DEATH**: Month: May — Day: 6 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/29/1872

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own home.

11. BIRTHPLACE (County & State, or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Josiah Marsh

14. MOTHER'S MAIDEN NAME: Leanna Wisner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** Address: Levi S. Utz, Westminster, Md. R. D. 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Rectal Bleeding — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO (b): Carcinoma of rectum — unknown

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 154X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/4, 1962 to 5/6, 1962 that (I) (we) last saw the deceased alive on 5/6 1962, and that death occured at 3:45 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/6/62

22c. PHYSICIAN'S NAME (Type): JULIUS CHEPKO M.D.

22d. ADDRESS: 85½ W. Green St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/8/62

23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

23d. LOCATION (City, town or county) (State): Silver Run, Carroll Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Richard A. Little

ADDRESS: Littlestown, Pa.

25e. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05694 05689

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster R.D.
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster Rural
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: OTTILIE — Middle: C — Last: VANFLEET

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Jan 1 - 1893

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Husk

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 158-16-3816

17. INFORMANT: Wm P. VanFleet — Address: Seattle - Wash

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 10 yrs
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 55, to 5-1 62, that (I) (we) last saw the deceased alive on 4-29, 1962, and that death occured at 3a M, from the causes and on the date stated above.

22a. SIGNATURE: M.C. Porterfield, M.D.

22b. DATE SIGNED: 5-3-1962

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): M.C. PORTERFIELD

22d. ADDRESS: HAMPSTEAD, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 5/62

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town or county) (State): Baltimore Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Tipton-Eline — **ADDRESS**: Hampstead Md

25a. REC'D BY REGISTRAR DATE: MAY 7 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05690

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 24 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18 3 V 01 · 4
d. STREET ADDRESS: 1408 Kingsway Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Elizabeth; Middle:; Last: Webb

4. DATE OF DEATH: Month: May; Day: 22; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 16, 1875

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Lennert

14. MOTHER'S MAIDEN NAME: Mary Richards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
903.7
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Comminuted intertrochanteric fracture of right hip — days
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Pt. fell to floor.

20c. TIME OF INJURY: Hour a.m. p.m.: 4-30-62 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town): Sykesville (County): Carroll (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): James T. Marsh, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 5-22-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5-24-62

22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery

22d. LOCATION (City, town, or country): Pikesville, Maryland (State):

23. FUNERAL DIRECTOR: Wm. Cook, Inc., ADDRESS: 1217 St. Paul Street, Baltimore 2

24a. REC'D BY REGISTRAR DATE: MAY 23 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05696 05691

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 4y. 5m. 3d.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tuscarora
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Grace — Middle: May — Lost: Wenner

4. DATE OF DEATH: Month: 5 — Day: 22 — Year: 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/5/89

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Chick

14. MOTHER'S MAIDEN NAME: Barnhouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Springfield Hospital records - Sykesville, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the cervix — INTERVAL BETWEEN ONSET AND DEATH: months

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): General metastasis — months

DUE TO (c): Cardiac failure — days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Involutional psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Doy, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 12/19/ 19 57 to 5/22/ 1962, that ☐ (we) last saw the deceased alive on 5/22/ 19 62, and that death occurred at 9:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/22/62

22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.

22d. ADDRESS: Springfield State Hospital
Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-24-62

23c. NAME OF CEMETERY OR CREMATORY: Mount Pleasant

23d. LOCATION (City, town, or county) (State): TAYLORSTOWN VA.

24. FUNERAL DIRECTOR'S SIGNATURE: Feete Funeral Home
ADDRESS: Brunswick md.

25a. REC'D BY REGISTRAR DATE: MAY 24 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis